



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

The Connecticut Women's Health Campaign

African American Affairs
Commission
American Cancer Society
American Heart Association
Commission on Aging
CT Association for Human
Services
CT Association of Nonprofits
CT Association of Substance
Abuse Agencies
CT Breast Cancer Coalition, Inc.
CT Citizen's Action Group
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CT Community Care, Inc.
CT Legal Rights Project
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CT Primary Care Association
CT Sexual Assault Crisis
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Network, Inc.
CT Women's Consortium
Disability Services, City of
New Haven
Hartford Gay & Lesbian Health
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Latino and Puerto Rican
Affairs Commission
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National Council of Jewish
Women
National Ovarian Cancer
Coalition CT
Older Women's League of NWCT
Permanent Commission on the
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Planned Parenthood of CT, Inc.
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Ruthe Boyea Women's Center,
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Valley Women's Health Access
Program, Griffin Hospital
Yale University School of
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Briefing Papers on Women's Health FEBRUARY 2005

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2005 Legislative Agenda

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Access to Healthcare

Medicaid Restoration and Expansion

- Seek restoration of funding to provide health insurance coverage to adult parents and caretakers with incomes below 185% of the federal poverty level.
- Support proposals to implement a family planning waiver, and to reform or revise the existing presumptive eligibility criteria for pregnant women.

State Administered General Assistance (SAGA) Restoration

- Lift the cap on appropriations for this program and seek restoration of coverage for non-emergency medical transportation and other "optional" services such as vision, podiatry, and home health care.
- Support proposals to institute certain due process rights and protections for enrollees.

Medical Malpractice Insurance

Support comprehensive reform proposals that protect women's access to health care by protecting physicians, especially obstetricians and gynecologists, from unreasonable insurance premiums while also protecting patients who are injured by malpractice.

Access to Prescription Medications

Support proposals to strengthen patient protections in programs with preferred drug lists or prior authorization requirements.

Reproductive Health Care

Protect access to the full range of reproductive health care and choice.

Breast Cancer

Support proposals to maintain funding and expand access to early detection services.

Prevention & Gender Competent Services

Gender Appropriate Behavioral Health Services

Support proposals for pilot programs to demonstrate and evaluate “best practices” in providing gender-appropriate treatment services for women and girls with behavioral health needs.

Nutrition

Support proposals that address the need for nutritional education and services in an effort to address preventable health conditions, particularly eating disorders and obesity.

Smoking Prevention and Cessation Programs

Support proposals to appropriate funds for Medicaid coverage of smoking prevention and cessation programs.

Domestic Violence Shelters

Support proposals to provide funding to increase shelter staff.

Sexual Assault Services

Protect funding for sexual assault centers in order to ensure that victims of sexual assault receive comprehensive rape crisis services, support the rights of sexual assault victims and support legislation to prevent and end sexual violence against women.

Supporting Community Health

Home and Community Based Services

Support proposals to provide home and community based services for chronically ill and disabled individuals under the age of 65.



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Restoration of Preventive Health Care for Low-Income Parents Under HUSKY A

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The Connecticut Women's Health Campaign supports restoration of funding to cover parents and relative caretakers of children eligible for HUSKY A (Medicaid) in households with incomes up to 185% of the federal poverty level, and restoration of presumptive and continuous eligibility rules to ensure that more low-income families have access to health care.

The Problem

Although HUSKY A (Medicaid) provides health insurance coverage for children in households up to 185% of poverty, their parents and relative caretakers are not currently covered. Most uninsured adults are in working families (8 in 10).¹ But adults in households with incomes up to 185% of poverty (approximately \$29,000 for a family of three) often cannot obtain health insurance because their employer does not offer it, or because they cannot afford to pay the premiums.

The rate of uninsured people in our state has risen – it now stands at 10%. But the rate among adults between the ages of 19 and 64 is even higher – 14%.² There are approximately 366,000 uninsured residents in our state, which, according to the Connecticut Health Policy Project, is more people than the populations of Hartford, New Haven and Waterbury combined. Among those who are uninsured, 58% have incomes below 200% of poverty.³

HUSKY A, or Medicaid, provides coverage for routine preventive care to keep people healthy, increase their employability, and detect medical problems early before they become more serious and expensive to treat. When people are uninsured, they delay seeking medical care and are 25% more likely to die prematurely. They also tend to overburden hospital emergency rooms and shift the burden of uncompensated care to all of us.⁴

Providing health insurance for the entire family under the same eligibility rules will also increase the number of children who receive health care.⁵ The majority of parents and caretaker relatives of children covered under the HUSKY A program are single mothers. Many work part-time in low wage occupations. Restoring coverage to parents and caretaker relatives up to 185% of poverty makes HUSKY A an accessible family insurance program for poor and near poor families. Healthy children need healthy parents.

What Can Be Done?

In 2000, the General Assembly voted to provide HUSKY coverage to parents and relative caretakers up to 185% of poverty. Soon after, the state faced a budget crisis and health care for these families was rolled back. But the need has not gone away – in fact, there are more uninsured people in Connecticut now than there were then. And in April 2005, up to 16,000 working parents or relative caregivers whose HUSKY coverage was restored by the courts will again become uninsured when that coverage ends.

- Restore HUSKY A eligibility for parents and relative caretakers of children enrolled in HUSKY in households up to 185% of poverty. This will create “family coverage” for low-income families and restore the eligibility levels that were approved in 2000.
- Restore “presumptive eligibility” and “continuous eligibility” procedures that streamline HUSKY enrollment for children. Presumptive eligibility allows for same-day enrollment in HUSKY thereby allowing children to get care when they need it. Continuous eligibility allows children to keep HUSKY for up to one year from enrollment or renewal regardless of small fluctuations in income and thus prevents them from being bouncing off and on the program. At least 7,000 children lost HUSKY coverage when we eliminated continuous eligibility in 2003.

For additional information, please contact:

Connecticut Women’s Health Campaign

Permanent Commission on the Status of Women

Leslie Gabel-Brett, Executive Director

18-20 Trinity Street

Hartford, CT 06106

860-240-8441

Leslie.Gabel-Brett@cga.ct.gov

CT Voices for Children

Covering Connecticut Kids and Families Project

Sharon Langer, Director

60 Gillett Street, Suite 204

Hartford CT 06105

Phone: (860) 548-1661

slanger@ctkidslink.org

Legal Assistance Resource Center

Jane McNichol, Executive Director

80 Jefferson Street

Hartford, CT 06106

860-278-5688

JMcNichol@larcc.org

Endnotes

¹ Connecticut Health Policy Project, Policymaker Issue Brief no. 12, August, 2004

² Kaiser Family Foundation, statehealthfacts.org, based on CPS, U.S. Census data, March, 2004, pp.2-3

³ *ibid.*, p. 6

⁴ Connecticut Health Policy Project, *op.cit.*

⁵ Lisa Dubay and Genevieve Kenney, “Expanding Public Health Insurance for Parents: Effects on Children’s Coverage under Medicaid, *Inquiry*, Vol. 38, October 2003, 1283-1302.



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Gender-Responsive, Trauma Informed and Culturally Sensitive Services Needed Across Service Delivery Systems for Women with Behavioral Health Needs

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The Connecticut Women's Health Campaign, in collaboration with the Roundtable on Women's Behavioral Health¹, recognizes and supports the need for comprehensive, integrated service models for women with co-occurring substance abuse, mental illness, and trauma².

The following definition of gender responsive is the foundation for creating and maintaining comprehensive, integrated service models for women:

Being gender-responsive means creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls and that addresses and responds to their strengths and challenges.³

The Problem

Over the past twenty years, much knowledge concerning the unique needs of women has been gained in the fields of mental health, substance abuse and trauma treatment. The most recent findings come from the Women, Co-occurring Disorders and Violence Study (WCDVS). Women in the study who received counseling that addressed all three aspects of their lives together (mental and substance abuse disorders and histories of violence [trauma]) improved more than women in usual care, which tends to be fragmented and uncoordinated. Women's symptoms also improved when they participated in the planning, implementation and delivery of their own integrated services.⁴ This knowledge has yet to be applied in the majority of programs serving women.⁵

Research on female development has revealed key differences in the psychosocial development of females and males.⁶ Such research is furthering our understanding of the role that socialization and relationships play in women's lives and behaviors. Research has also highlighted important strengths and challenges associated with females' cultural and ethnic backgrounds.⁷ For example, new theories are highlighting culturally influenced differences in female socialization processes, female responses to abuse, and female risk/protective factors for system involvement.⁷ In order to operationalize what we are learning about delivering gender responsive, trauma informed and cultur-

ally relevant services, policy makers, administrators, direct services providers and funders need to acknowledge women's differences and build an infrastructure that embraces women's gender and cultural/ethnic strengths.

What Can Be Done

Using the following six guiding principles and strategies for implementing them,⁸ continue to –

- increase awareness among consumers, providers, administrators, funders and legislators of the need for gender responsive, trauma informed and culturally sensitive services within all delivery systems that serve girls and women;
- work collaboratively with state agencies including, but not limited to, the Departments of Mental Health and Addiction Services (DMHAS); Children and Families (DCF); Correction (DOC) and the Court Supported Services Division (CSSD) of the Judiciary Branch in their efforts to design, implement and maintain gender-responsive, trauma informed and culturally sensitive services to the girls and women who seek care and services from one or more of these state agency's systems; and
- recognize and support successful gender-responsive programming and services.

Guiding Principles:

Evidence drawn from a variety of disciplines and effective practice suggests that addressing the realities of women and girls' lives through gender-responsive policy and programs is fundamental to improved outcomes at all levels of service. The six guiding principles that follow are designed to address system concerns about the services and treatment of females in the social service system.

- Gender - Acknowledge that gender makes a difference.
- Environment - Create an environment based on safety, respect, and dignity.
- Relationships - Develop policies, practices and programs that are relational and promote healthy connections to family, children, peers, and the community.
- Services - Address the issues of substance abuse, mental health, and trauma through comprehensive integrated, and culturally relevant services.
- Socioeconomic Status - Provide women and girls with opportunities to improve their socioeconomic status.
- Community - Establish a system of comprehensive and collaborative community services.⁸

Together with the general strategies for their implementation, the guiding principles provide a blueprint for a gender-responsive approach to the development of effective policy.

General Strategies:

To implement the guiding principles, the following overarching strategies can be applied to each of the principles:

- | | |
|-------------|--|
| ▪ Adopt | Each principle is adopted as policy on a system-wide and programmatic level. |
| ▪ Support | Principle adoption and implementation receives the full support of the administration. |
| ▪ Resources | An evaluation of financial and human resources is done to ensure that adequate implementation and allocation adjustments are made to accommodate any new policies and practices. |

- **Training** Ongoing training is provided as an essential element of the implementation of gender-responsive practices.
- **Oversight** Oversight of the new policies and practices is included in management plan development.
- **Congruence** Procedural review is routinely conducted to ensure that the procedures are adapted, deleted, or written for new policies.
- **Environment** Ongoing assessment and review of the culture/environment take place in order to monitor the attitudes, skills, knowledge, and behavior of administrative, management, and line staff.
- **Evaluation** An evaluation process is developed to consistently assess program management and services.⁸

For additional information, please contact:

The Connecticut Women's Consortium

Marijane Carey or Cinda Cash

205 Whitney Avenue

New Haven, CT 06511

mcarey@womensconsortium.org, ccash@womensconsortium.org

Endnotes

¹The CT Roundtable on Women's Behavioral Health, a joint initiative of the Permanent Commission on the Status of Women (PCSW) and the CT Women's Consortium (CWC), is a vehicle for sharing practical information that can inform and enhance access to services; advocating for available, affordable and appropriate gender specific policy and programs; and collaborating and coordinating the full range of behavioral health and related services needed by women. The Roundtable has been working

on increasing, within state agencies' service delivery systems, the provision of gender responsive, trauma informed and culturally sensitive programs and policies.

²The Women, Co-occurring Disorders and Violence Study (WCDVS), a five-year study conducted by SAMHSA of over 2,000 women with co-occurring mental and substance abuse disorders and trauma history.

³Bloom & Covington, October 5, 2004 "*Creating Gender-Responsive Services for Women and Girls in Connecticut*". Paper prepared for the CT Women's Consortium, New Haven, CT.

⁴The Women, Co-occurring Disorders and Violence Study (WCDVS)

⁵Bloom, eds., 2003. *Gendered Justice: Addressing Female Offenders*. North Carolina: Caroling Academic Press.

⁶Gilligan, 1977. "In a Different Voice: Women's Conception of Self and Morality." *Harvard Educational Review*, 47. and Gilligan, 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

⁷Benedict, 2003. *Capacity Building: Developing a Gender Responsive Justice System for Young Women in the State of Rhode Island/ A Focus Group Study*.

⁸Bloom & Covington.



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Medicaid Coverage of Smoking Cessation

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The Connecticut Women's Health Campaign supports increased state spending on programs to prevent and treat tobacco addiction in women and girls in Connecticut, including coverage under Medicaid. Smoking is the leading known cause of preventable death and disease among women.

The Problem

In Connecticut 19.5% of all adults smoke and 4,800 die annually from their own smoking.¹ Among the adult smokers in the state, 18.2% are women² and 7% are pregnant women.³ Tobacco use has been a women's health issue dating back to the 1920's when tobacco companies recognized women as a target for their product. Since the 1980's there has been a dramatic increase in smoking related illnesses among women, including lung cancer and heart disease.⁴ Smoking increases the risks for pregnant women and puts healthy fetal development at risk as well. Pregnant women may experience a variety of poor pregnancy outcomes resulting from tobacco use, including spontaneous abortions, stillbirths, sudden infant death syndrome and low birth weight babies.⁵ Women who smoke but are not pregnant may also risk their reproductive health including menstrual problems, reduced fertility and premature menopause.⁶ Connecticut's next generation of young women is beginning to smoke in large numbers – 26% of girls in grades 9-12 smoke compared to 24.9% of boys.⁷

29% of Connecticut Medicaid recipients are reported smokers.⁸ Medicaid recipients who choose to quit smoking are often not able to afford cessation aids that would increase their success and consequently improve their health. The health care cost related directly with smoking in the state is \$1.27 billion, and \$336 million of this is paid annually by the state Medicaid program.⁹ It is much more cost effective to pay for smoking cessation. The cost of providing smoking cessation services to one smoker on Medicaid ranges from approximately \$200 for 12 weeks of counseling to \$700 for 12 weeks of counseling and smoking cessation aids (e.g., Zyban). It is estimated that 2% to 10% of Medicaid recipients who smoke will utilize cessation services.¹⁰

16% of Connecticut's pregnant women who smoke are Medicaid recipients.¹¹ The state spends \$3 million on Smoking Attributable Neonatal Expenditures – \$810 is spent on each pregnant woman on Medicaid who smokes.¹² The CDC (Center for Disease Control and Prevention) states that "Smoking cessation programs remain a crucial strategy for preventing poor birth outcomes and decreasing the social and financial cost of smoking during pregnancy."¹³

The state of Connecticut receives Tobacco Settlement funds annually; in 2004 the payment totaled \$113.9 million.¹⁴ Connecticut spent only \$57,500 of the Tobacco Settlement money on tobacco control in FY2004,¹⁵ and the remaining settlement monies were placed in the state's general fund. The CDC (Center for Disease Control and Prevention) recommends spending a minimum of \$21.24 million on tobacco control and prevention; at the current rate, Connecticut spends 0.3% of the recommended minimum.¹⁵ Connecticut currently ranks 45th in the nation for state funding of tobacco control programs.¹⁶

What We Can Do

In the United States there are currently 39 states and the District of Columbia that offer Medicaid coverage of smoking cessation.¹⁷ Connecticut currently does not fund smoking cessation. Funds should be allocated to the state Medicaid program to provide smoking cessation options to Medicaid recipients. In 2003, the General Assembly passed *CGS Chapter 319v Medical Assistance, Sec. 17b-278a Coverage for Treatment for Smoking Cessation*, which requires the Commissioner of the state Department of Social Services to amend the Medicaid state plan to provide coverage for treatment for smoking cessation when such treatment is ordered by a licensed health care professional.

Legislative Proposal: To appropriate funding from the Tobacco Settlement Fund to the state Department of Social Services for the fiscal year ending June 30, 2007 for the purpose of implementing the Department of Social Services Medicaid state plan to provide smoking cessation services.

For additional information, please contact:

MATCH Coalition
78 Beaver Road
Wethersfield, CT 06109
(860) 721-6888
www.matchcoalition.com

American Cancer Society
538 Preston Avenue
Meriden, CT 06450
(203) 379-4700
www.cancer.org

American Lung Association of Connecticut
45 Ash Street
East Hartford, CT 06108
(860) 289-5401
www.alact.org

American Heart Association
5 Brookside Drive
P.O. Box 5022
Wallingford, CT 06492
(203) 294-0088
www.americanheart.org

Sources

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Medical Malpractice Insurance and Access to Women's Health Care

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The Connecticut Women's Health Campaign supports a comprehensive solution to the problem of rapidly rising medical malpractice premiums that protects women's access to reproductive health care, particularly obstetrical care, while balancing the rights and health needs of injured patients. A comprehensive solution includes strengthening patient safety measures; reforms in malpractice litigation rules to screen out frivolous cases and encourage mediation; stronger regulation of insurance rate setting; more efficient state review and oversight of doctors; and the creation of government sponsored funds and programs to help spread the risks and the contributions required to provide adequate health care and compensation to injured patients.

The Problem

The current crisis caused by rapidly increasing medical malpractice premiums, particularly for obstetrician/gynecologists (OB/GYN's), threatens women's health because it is causing doctors to withdraw from the field of obstetrics and, in the most extreme case in Connecticut, nearly closed down the only OB/GYN practice available in a region. According to physicians from Women's Health Connecticut, a large statewide medical practice, premiums for OB/GYN's have nearly quadrupled since 2001: premiums were approximately \$26,000 per year in 2001, and are now approximately \$98,000 per year. By next year, these doctors expect their premiums to be nearly \$130,000 per year, per doctor. As a result, some doctors have stopped delivering babies so their premiums will be less, and other doctors are covering for large numbers of their colleagues.

There are many underlying causes for the rapid increase in malpractice premiums. According to a report issued by the Connecticut General Assembly,¹ increasing premiums may be the result of a combination of factors including changing market conditions, litigation costs, and the rapidly increasing costs of health care and medical errors. The Committee report concluded that the imposition of caps on non-economic damages in jury awards would likely have some effect on reducing the growth in premiums, but further concluded that the size of the effect is "speculative." They cited a projection from one of the state's largest insurers that a cap of \$250,000 would result in 10% less of an increase for one year. The Committee recommended the creation of a state sponsored premium assistance fund.

Caps on non-economic damages have a harmful and disproportionate effect on women who are victims of medical malpractice. Empirical research conducted by law professor Lucinda Finley on gynecological malpractice cases over the past ten years in California and Florida shows that non-economic damages comprised approximately 75% of women's total awards. The reason is that the harm suffered by women in these cases include impaired fertility or sexual functioning, miscarriage, incontinence, and disfigurement of intimate areas of the body and these consequences, while very significant, are not directly related to economic losses. Finley concludes that capping non-economic damages will have a discriminatory impact on women patients that will be "the greatest when women experience the most profound sort of harm to their sexual and reproductive lives."²

What Can Be Done

A comprehensive solution includes the following elements:

- **Employ strategies to increase patient safety and reduce medical error.** Provide incentives such as state guaranteed loans of hospitals and premium discounts to providers to institute new and proven safety methods. Improve investigations and toughen discipline against providers found to be negligent, and provide adequate funding to the Department of Public Health to achieve this important goal. Expand continuing medical education to reduce errors and improve the over-all quality of health care.
- **Implement safeguards in the insurance market to protect and compensate patients injured by malpractice.** Proposals for prior rate approval, mandatory issue of policies, and stricter enforcement of limits on attorneys' fees are examples of such safeguards. CWHC also recommends that insurers be required to offer pro-rated premiums to physicians who work part time so that doctors can balance their work and family obligations.
- **Make the tort system efficient, fair and, where appropriate, less adversarial.** Pre-screening of cases, certificate of good faith, mediation, and incentives to reach fair settlements are useful strategies to achieve these goals.
- **Create an Injured Patient Fund** and administer it in a manner similar to the Workers' Compensation Fund. A state-sponsored reinsurance fund would also help to spread the risk for very costly medical care.

For additional information, please contact:

Leslie J. Gabel-Brett
Executive Director
Permanent Commission on the Status of Women
18-20 Trinity Street
Hartford, CT 06106
860-240-8300
Leslie.Gabel-Brett@cga.ct.gov

footnotes

¹ Medical Malpractice Insurance Rates, Program Review and Investigation Committee, Connecticut General Assembly, December, 2003, Report Digest

²Lucinda Finley, Professor of Law, University of Buffalo School of Law, working paper on medical malpractice



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Community Support for Women with Disabilities

The Connecticut Women's Health Campaign

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CT Association for Human Services
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The Connecticut Women's Health Campaign supports the continuation and expansion of current services to all women with disabilities, regardless of age, in order to prevent inappropriate and premature institutionalization and to deinstitutionalize when appropriate.

The Problem

There is a significant gap in the continuum of long term care services for individuals between the ages of 18 and 64 in Connecticut. Individuals who need help with activities of daily living but have limited family support, have cognitive impairment, and/or have needs that change and progress over time are unable to access the current Medicaid Waivers or state-funded programs. The Connecticut Home Care Program for Elders (CHCPE) is only available for those over the age of 65. The Medicaid Personal Care Assistance (PCA) Waiver requires that individuals have the ability to self-direct their care.

7,436 people under the age of 65 currently live in nursing homes in our state. Many of these with cognitive and/or physical impairments could live in the community if the right supports and care management were available. People with chronic illnesses and disabilities caused by diseases such as Huntington's, Parkinson's, Alzheimer's, Multiple Sclerosis, HIV/AIDS, and strokes could be helped.

What Can Be Done?

Connecticut should seek a waiver that will establish a pilot program of 100 slots to serve people with disabilities who are under age 65 with a program similar to the Connecticut Home Care Program for Elders. The proposed pilot would include care management, the identical service caps and the same service package that is offered under the program for those over age 65 (the CHCPE). It has been estimated that the proposal, offering 100 slots, could save the state of Connecticut approximately \$3.6 million dollars annually.

Connecticut's Long-Term Care Plan specifically states, "The overall goal for Connecticut's long-term care system should be to offer individuals the services and supports of their choice in the least restrictive setting."

For additional information, contact:

Gayle Kataja
Connecticut Community Care, Inc.
100 Great Meadow Road
Wethersfield, CT 06109
860-257-1503
www.ctcommunitycare.org

Jill Zorn
National Multiple Sclerosis Society, Greater Connecticut Chapter
705 North Mountain Road, Suite G102
Newington, CT 06111
860-953-0601
www.ctnmss.org

Sources

Connecticut Department of Social Services (Home Care at a Glance) SFY 2003e Annual Report to the Legislature.



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

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Women Experiencing Gambling Problems in Substance Abuse and Mental Health Treatment Settings

The Connecticut Women's Health Campaign supports requiring all state-funded behavioral health programs to provide gender competent assessment, treatment and other necessary services to meet the complex needs of women with behavioral health problems. Problem gambling is an addiction disorder, which is increasing faster among women than among men, and requires treatment that is gender appropriate.

The Disorder

Problem gambling describes any gambling behavior that chronically or episodically results in negative consequences. Pathological gambling, commonly called "compulsive" or "addicted gambling", is the most severe form of problem gambling. It is a distinct psychiatric disorder recognized by the American Psychiatric Association since 1980, and is defined as a chronic and progressive failure to resist impulses to gamble despite mounting negative consequences. Lying to hide gambling, over spending, neglecting responsibilities and important relationships, losing employment and engaging in criminal behavior are among the typical consequences.

The Problem

With recent dramatic increases in the variety and availability of gambling opportunities has come growth in the numbers of women experiencing gambling related problems. One result is that women gamblers now comprise the fastest growing group of individuals seeking treatment at Connecticut's problem gambling treatment programs.ⁱ Prior to the early 1990's, treatment-seeking gamblers were almost exclusively male.ⁱⁱ Currently, about 40% of gamblers in treatment are women.ⁱⁱⁱ Most are between the ages of 40-60,^{iv} suggesting that societal roles (transitions in child rearing and work responsibilities) and biology (menopause and aging) may play a part in the development of their gambling problems.

Compared to treatment seeking male gamblers, women gamblers tend to be older, have briefer gambling histories^v, and are more likely to have received help for mental health problems.^{vi}

Childhood maltreatment is prevalent among pathological gamblers, and women with gambling problems have more severe histories of abuse and neglect than men have.^{vii} Similar to substance abusing women, female problem gamblers report high levels of emotional neglect and abuse, physical neglect, and physical and sexual abuse.^{viii} Surprisingly, the lifetime rates of abuse or neglect are slightly higher among treatment-seeking women gamblers than among treatment-seeking female substance abusers.^{ix}

Problem gambling among women appears to be highly correlated with mood and anxiety disorders, substance abuse disorders, and Attention Deficit Hyperactivity Disorder.^x In addition, gambling in women may be associated with Post Traumatic Stress Disorder.^{xi}

Female problem gamblers experience significant challenges to recovery. They are more likely than men to be living with a problem gambler or problem drinker.^{xii} Twenty-five percent of them have dependent children at home, and 40% of women problem gamblers earn annually less than \$40,000.^{xiii}

Problem gambling often occurs with other difficulties: the rate of problem and pathological gambling for those in mental health and substance abuse treatment settings is four-to-ten times higher than the general population.^{xiiii} Common problems include: depression, anxiety, suicidal ideation, family or spouse conflict, and family neglect. A host of financial problems such as difficulty paying household bills and past or pending bankruptcy often accompany problem gambling. Illegal acts to continue gambling or solve desperate financial problems are also common.^{xv}

While it is generally accepted that women in substance abuse recovery have complex and differing needs from their male counterparts, the case for gender competent treatment for women with gambling problems has not been made. As a result few female problem gamblers receive gender specific services. In fact, there may exist a gender bias that refuses to recognize problem gambling as a significant concern for women in both treatment settings and the community.

What Can Be Done?

Screening for gambling problems: Considering the rate of co-morbid problem gambling and mental health and substance abuse disorders, it is critical for health providers to screen for problem gambling on intake and provide treatment or referral.

Training service providers in assessment and referral: Training and skill building is needed to raise staff awareness and commitment to addressing problem gambling. This is the first step toward the integration of problem gambling intervention and treatment protocols within systems of care already utilized by the problem gamblers.

Conducting research: Scientific study of gender differences across the life-span will aid in the development of more effective treatment, intervention and prevention strategies for women of all ages.

For additional information, please contact:

Department of Mental Health and Addiction Services
Problem Gambling Services
Connecticut Valley Hospital, Box 351, Russell Hall
Middletown, CT 06457
860-344-2244

Connecticut Council on Problem Gambling
47 Clapboard Hill Road
Guilford, CT 06437
203-453-0138

Connecticut Problem Gambling Helpline
24-hour, toll-free, confidential
1-800-346-6238

Connecticut Women's Consortium
205 Whitney Avenue
New Haven, CT 06511
203-498-4184

Endnotes

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- iii Petry, A comparison of young, middle age and older adult treatment seeking pathological gamblers. *The Gerontologist* (2002)
- iv Petry, A comparison of young, middle age and older adult treatment seeking pathological gamblers. *The Gerontologist* (2002)
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- vi CT Council on Problem Gambling, Helpline Report, 2002
- vii Petry, et.al., Childhood maltreatment in male and female pathological gamblers, under review
- viii Petry, et.al., Childhood maltreatment in male and female pathological gamblers, under review
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- xi Petry, et.al, Childhood maltreatment in male and female pathological gamblers, under review
- xii Ladd and Petry, A comparison of pathological gamblers with and without substance abuse treatment histories. *Experimental and Clinical Psychopharmacology*, under review
- xiii CT Council on Problem Gambling, Helpline Report, 2000
- xiiii Shaffer, Hall and Vander Bilt, Estimating the prevalence of disordered gambling behavior in the U.S. and Canada (1999)
- xv CT Council on Problem Gambling, Helpline Report, 2002



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Eating Disorders – A Public Health Crisis NOT a Lifestyle Issue

The Connecticut Women's Health Campaign

African American Affairs
Commission
American Cancer Society
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Latino and Puerto Rican
Affairs Commission
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National Council of Jewish
Women
National Ovarian Cancer
Coalition CT
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of Nursing
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Central CT State University
UConn School of Allied Health-
Asian American Studies
Institute
UConn Women's Center
Urban League of Greater
Hartford, Inc.
Valley Women's Health Access
Program, Griffin Hospital
Yale University School of
Medicine

The Connecticut Women's Health Campaign supports adequate access to health care, including appropriate treatment for eating disorders, as well as additional options for treatment. Eating disorders are a serious public health problem, and there is a need for awareness, education, prevention and research.¹

The Problem

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses. Because of their complexity, eating disorders require a comprehensive treatment plan involving medical care and monitoring, psychosocial interventions, nutritional counseling and, when appropriate, medication management.² It is estimated that 1 in 5 women struggle with an eating disorder or disordered eating³ and up to 24 million people suffer from an eating disorder in the United States.⁴ The health risks of binge eating disorder are most commonly those associated with clinical obesity. Eating disorders have the highest mortality rate of any mental illness, and the mortality rate associated with anorexia nervosa is twelve times higher than the death rate of ALL causes of death for females 15-24 years old.⁵

Eating disorders are serious, potentially life-threatening problems. The current mental health care system's reimbursement policies and 'managed care' guidelines make it very difficult for eating disordered patients to receive treatment. These illnesses can have multiple causes, with possible physical or genetic predisposing factors, in addition to multiple psychological issues. The illness process leads to significant physiological changes requiring medical treatment in addition to psychiatric treatment, but the reimbursement system does not allow for a holistic approach, wherein the costs of treatment might be more fairly shared between medical and psychiatric insurance benefits. Furthermore, some companies have very specific and inadequate guidelines for treatment, which fall far short of the current recommendations by the American Psychiatric Association (2000).⁶

Eating disorders frequently co-occur with other psychiatric disorders such as depression, substance abuse, and anxiety disorders. Additionally, people who suffer from eating disorders can experience a wide range of serious physical health complications, including osteoporosis, serious heart conditions, kidney failure and possibly death. Recognition of eating disorders as real and treatable diseases, therefore, is critically important. Because of the complex nature of eating disorders, a comprehensive treatment plan is required that involves, but is not limited to, medical care and monitoring, psychosocial interventions, and nutritional counseling.

What can be done?

Since eating disorders do not occur in a vacuum and often result within a context of stress or trauma, it is important for the government to promote initiatives that support the healthy development of children. This includes actions such as offering healthy role models, teaching about nutrition and healthy eating, offering a constructive educational environment, teaching effective coping behaviors, and de-emphasizing the weight/appearance of a child.⁷

Specific initiatives would include:

- Increase resources for research, education, prevention, and improved training.
- Promote programs and activities that support the healthy development of children.
- Support for improved access to care.
- Prevent health insurance companies from having an exclusionary clause for the treatment of eating disorders.
- Prevent health insurance companies from avoiding the requirement to offer mental health parity by offering many policies of which only one includes such coverage (this meets the requirement to offer mental health treatment).
- Change the qualification of medical necessity required for treatment of mental health issues from “being a risk to self or others” to one that is more appropriate for eating disorders. Professionals in the field such as experts from the American Psychiatric Association have developed criteria for determining medical necessity specific to eating disorders. Health insurance companies should use such criteria.
- Include eating disorders in Mental Health Parity initiatives.

For additional information, please contact:

Eating Disorders Coalition
611 Pennsylvania Avenue, SE #423
Washington, DC 20003-4303
202-543-9570
www.eatingdisorderscoalition.org

Kathy Fluckiger
Associate Director, Women’s Center
University of Connecticut
417 Whitney Road, Unit 1118
Storrs, CT 06269-1118
860-486-4738

National Eating Disorders Association
603 Stewart St., Suite 803
Seattle, WA 98101
206-382-3587
www.nationaleatingdisorders.org

The Renfrew Center Foundation
475 Spring Lane
Philadelphia, PA 19128
877-367-3383
www.renfrew.org

Endnotes

¹ Prevalence and mortality rates of eating disorders are not tracked by the US government. Therefore, all estimates are based on studies conducted by private researchers. We have listed sources in this particular footnote that reference prevalence rates in their studies/articles: Culberg, J., & Engstrom-Lindberg, M. Prevalence and incidence of eating disorders in a suburban area. *Acta Psychiatrica Scandinavica*, 1998, 78, 314-319. Fisher M, Golden NH, Katzman DK, et al. Eating disorders in adolescents: A background paper. *Journal of Adolescent Health*, Vol. 16, 1995. Garner, DM, Garfinkel, PE (Eds). *Handbook for treatment of eating disorders*. 1997. New York: Guilford Press. Hoek, HW. Review of the epidemiological studies of eating disorders. *International Review of Psychiatry*, 1991, 5, 61-74. The US Dept. of Health & Human Service’s Office on Women’s Health, www.4women.gov & The US Dept. of Health & Human Service’s National Institute of Health www.nimh.nih.gov Yager J, Andersen A, Devin M, Mitchell J, Powers P, Yates A. American Psychiatric Association practice guidelines for eating disorders. *American Journal of Psychiatry* 1993; 150:207-28.

² American Psychiatric Association Work Group on Eating Disorders. *American Journal of Psychiatry*, 2000; 157 (1 Suppl): 1-39.

³ Eating disorders include anorexia, bulimia and binge eating disorders (classified as mental illnesses in the DSM IV). Disordered eating is not a classified mental illness. Disordered eating is characterized by atypical behaviors such as continuous restrictive dieting, bingeing and purging, yet the individual does not fit all the criteria to have a diagnosable eating disorder. It has been estimated that up to 25 million men and women in the US struggle with disordered eating or sub-clinical eating disorders.

⁴ This estimated figure was created by utilizing current US Census numbers and statistics from the National Institute of Mental Health’s (NIMH) guide, *Eating Disorders: Facts About Eating Disorders and the Search for Solutions* (i.e. 3.7% females suffer from Anorexia, 4.2 females suffer from Bulimia and 5% of males and females suffer from Binge Eating Disorder. The 24 million figure combines all three eating disorders, anorexia, bulimia and binge eating disorder. The figure of 8-10 million people suffering from an eating disorder is a common figure used; however, this underestimates by not including all ages, both genders and all three eating disorders.

⁵ *American Journal of Psychiatry*, Vol. 152 (7), July 1995, pp 1073-1074, Sullivan, Patrick F.

⁶ National Eating Disorders Association

⁷ Eating Disorders Coalition



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

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The Benefits of Family Planning Programs

The Connecticut Women's Health campaign supports a woman's right to access to complete and accurate information and services relative to reproductive health care.

The Problem

Publicly funded family planning programs provide low-income women with clinical and educational services related to contraception, infertility, and sterilization. Such programs are a cost-effective way to reduce unintended pregnancies, treat and prevent sexually transmitted diseases, and improve the overall health of patients by offering comprehensive medical care and counseling. **For every public dollar spent on family planning, three dollars are saved on pregnancy-related costs and newborn care each year.** Family planning services include:

- Annual gynecological exams and Pap tests;
- Testing and treatment of sexually transmitted infections;
- HIV testing and counseling;
- All FDA-approved contraceptives, emergency contraception and counseling;
- Pregnancy options counseling;
- Referrals for prenatal care and abortion services.

The Medicaid program is the nation's largest source of public funding for family planning, covering four out of ten births in the United States. It provides funds for contraception, gynecological care, treatment and prevention of sexually transmitted diseases (STD's), and for abortions in limited circumstances. Approximately 18 states have taken steps to expand eligibility for Medicaid services (commonly referred to as family planning waivers), thereby increasing the number of women able to participate in family planning programs. A 2002 study of six of these states revealed that the expansion of these services actually saved money for both the federal government and the individual state. The federal government matches every dollar spent by state Medicaid programs on family planning at a rate of 90%.

A proposed federal 'block grant' of the Medicaid program could have dire consequences to women's health by allowing states to restrict or eliminate family planning programs or to charge co-pays for these services, making adequate preventive health care once again out of reach for low income women.

What Can Be Done?

A Connecticut family planning waiver would improve access to family planning services for adults of child-bearing age and could reduce state Medicaid costs by:

- Reducing the number of unintended pregnancies;
- Improving birth outcomes in the Medicaid program;
- Slowing the rate of growth in Medicaid-paid pregnancies and deliveries; and
- Reducing expenditures for prenatal care, delivery and infant care.

Cost effective family planning waivers could cover:

- Counseling services and patient education
- Examinations including screening tests provided during family planning visits
- Laboratory exams and tests in conjunction with family planning visits
- Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception
- Sterilization for individuals 21 and over

For additional information, please contact:

The Alan Guttmacher Institute
1301 Connecticut Avenue NW
Suite 700
Washington, DC 20036
<http://www.guttmacher.org>

The Institute for Reproductive Health Access
427 Broadway, 3rd Floor
New York, NY 10013
<http://www.prochoiceny.org>

Planned Parenthood of Connecticut
345 Whitney Avenue
New Haven, CT 06511
<http://www.ppct.org>

Sources

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"CMS Study of Medicaid Family Planning Waiver Program," The Alan Guttmacher Institute, January 26, 2004.

"Doing More for Less: Study Says State Medicaid Family Planning Expansions Are Cost-Effective," Rachel Benson Gold, The Guttmacher Report on Public Policy, March 2004.

"Medicaid and Reproductive Health Care," The Institute for Reproductive Health Access, available online at <http://www.prochoiceny.org>.



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Increased Access to Domestic Violence Services

The Connecticut Women's Health Campaign supports increased funding to domestic violence shelters so that they have adequate staff to address the needs of battered women and their children.

The Problem

Domestic violence is commonly defined as a pattern of coercive control that one person exercises over another. National estimates range from 960,000 incidents of violence against a current or former spouse, girlfriend or boyfriend per year (U.S. Department of Justice, 1998) to 3.9 million women who were physically abused by their husbands or live-in partners per year (The Commonwealth Fund, 1999). Abusers use physical and sexual violence, threats, intimidation and economic deprivation as a way to dominate their partners. Relationships in which one partner uses assaultive behavior and coercion to maintain dominance can be found in all populations regardless of race, ethnicity, sexual orientation, age, religion, education or socio-economic status.

In FY 03, Connecticut's domestic violence programs provided shelter for 2,349 victims of domestic violence and their children. 49,608 individuals sought the services of the domestic violence programs. The programs reported receiving 25,113 crisis calls and answered 52,751 requests for information and referrals. 15,711 adult victims and 857 child victims who did not need emergency shelter received support services from our programs including but not limited to counseling, support groups, advocacy and safety planning. 30,691 court referred victims received services from staff and volunteer advocates housed in the criminal courts across Connecticut.

The unfortunate reality is that women and children experience domestic violence crises at all hours of the day and night. When they come to a shelter, women and children have just survived a traumatic event. They are uprooted from their homes, families, support networks and routines and anxious about making new connections to schools, medical and legal professionals, community resources and sources of support. We must put victims first by offering comfort and support immediately after they are abused.

Domestic violence isn't something that happens to someone else. It is our family, our friends, and our co-workers. We must work together to make every home a safe home.

Connecticut domestic violence programs receive bare bones funding. On an average, domestic violence programs receive \$30.00 per victim per day to provide emergency shelter and support services. In contrast, those who provide community based services for offenders receive at least twice as much per day. **Victims have the right to have all their needs met.** Yet, because of limited funding, many of their needs go unmet. It is important that victims of domestic violence be helped 24 hours a day, 7 days a week.

The Solution

Strategies must be created and implemented to meet victims' basic needs while ensuring their immediate needs are being met. As we have known for more than a decade, shelters and crisis services are only the beginning for victims attempting to create a life free from violence for themselves and their children. With appropriate funding and support, domestic violence programs in Connecticut will work to provide solutions and also stop the intergenerational cycle of violence. Virtually every area of life is affected by domestic violence. Only by providing adequate services will domestic violence be reduced, thereby building and maintaining healthy communities.

As communities become more aware of the complexity of domestic violence, families are left in danger if an inappropriate intervention or no intervention occurs. The level of service available must continue to increase in proportion to the existing needs. Therefore, the Connecticut Coalition Against Domestic Violence and its member programs are urging legislators to increase state funding and to allocate the equivalent of \$1.00 per resident of Connecticut towards domestic violence services statewide.

For additional information, please contact:

Connecticut Coalition Against Domestic Violence
90 Pitkin Street
East Hartford, CT 06108
Telephone: (860) 282-7899
Fax: (860) 282-7892
www.ctcadv.org

Sources:

U.S. Department of Justice, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*, March 1998.
The Commonwealth Fund, *Health Concerns Across a Women's Lifespan: 1998 Survey of Women's Health*, May 1999.



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Health Care Workforce Shortages in Connecticut

The Connecticut Women's Health Campaign

African American Affairs Commission
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The Connecticut Women's Health Campaign supports measures to ensure that Connecticut has a diverse workforce that meets the evolving health needs of the people of Connecticut. A strong health care workforce with appropriate training and compensation is necessary to the delivery of a broad range of services and assures access to vital health care. A majority of healthcare workers are women who need adequate wages and benefits and career ladders to achieve economic security.

The Problem

Connecticut is experiencing health care workforce shortages that seriously threaten the welfare of the people of Connecticut. Connecticut's nursing shortage will grow to a staggering 55 percent vacancy rate by 2020, estimated to be the fifth worst in the nation. Shortages of allied health professionals have grown dramatically over the past five years.¹ For example, the hospital vacancy rate for radiation therapists has increased from three percent in 1997, to over 20 percent in 2002.² Enrollment in schools of pharmacy has stagnated or declined at a time when the demand for pharmacy services is increasing sharply.³ Health care workforce shortages are exacerbated by a growing demand for health care services due to the aging of the population and the availability of more effective health care treatments.

What can be done?

Ensuring a diverse workforce that meets the evolving needs of the people of Connecticut is a long-term effort that depends on an increased educational capacity within schools of nursing, pharmacy, and allied health. The Connecticut Women's Health Campaign recommends that the General Assembly provide the state's institutions of higher education with the resources necessary to expand their capacity to educate more students in these health professions experiencing shortages. Along with expanding their student capacity, health professional schools must have the resources to recruit qualified faculty and to design and implement innovative programs that respond to the needs of today's students, who are typically older and have family and work responsibilities. Program innovations should include on-line, part-time, evening, and weekend coursework.

The Connecticut Women's Health Campaign also urges the General Assembly to adopt a range of programs to address the underlying causes of health care

workforce shortages. The negative consequences of widespread workforce shortages are both systemic and self-propagating. Shortages lead to increased stress on the job and to unavoidable overtime. Frequent overtime ultimately leads to provider burnout, resignation, and, in turn, to worsening shortages. Within a health care institution, shortages in one discipline lead to shortages in other disciplines. Similarly, shortages in one level of care (e.g., home care) can lead to shortages in other levels of care (e.g., hospitals). Moreover, the supply of health care professionals has a real impact on patient safety and quality of care. A number of well-designed studies have demonstrated a direct relationship between nurses' patient load and the incidence of adverse medical events, including patient deaths.⁴

The measures that should be considered include:

- Developing and implementing a long-range plan for addressing health care workforce shortages, including career ladders;
- Establishing a semi-autonomous Health Care Workforce Policy Board charged with monitoring workforce shortages, making policy recommendations to the relevant legislative committees, state agencies, and key stakeholders, and serving as a public forum for the ongoing consideration of health care workforce issues;
- Establishing long-term and broad-based programs to recruit students into health careers;
- Providing to the state's institutions of higher education the resources necessary to expand their capacity to train those health professionals experiencing shortages; and
- Funding scholarship, loan, and loan repayment programs for students enrolled in health professions educational programs.
- Funding programs that train and educate a variety of providers who choose to work in community health centers and clinics that serve the disadvantaged and underserved in order to address disparities in health care and deliver culturally appropriate care.⁵

Particular attention must be paid to reversing the lack of diversity in the health care workforce. Ensuring access and culturally competent care requires that the increasing diversity in the general population be reflected in the composition of the health care workforce.⁶ Therefore, Connecticut should adopt a comprehensive program for recruiting students, especially minority students, into the health care professions. Addressing widespread, persistent, and worsening shortages in the nursing, pharmacy, and allied health professions requires a comprehensive and sustained effort.

For additional information, please contact:

Laurie Julian, J.D., M.P.H.
Government Affairs
Program
Connecticut Primary Care Association
90 Brainard Road
Hartford, CT 06114-1685
(860) 727-0004
ljulian@ctpca.org

Charles Huntington, M.P.H., PA
Associate Director, Connecticut AHEC
Program Administrator, Connecticut Health
University of Connecticut Health Center
263 Farmington Avenue, MC 2928
(860) 679-7968
huntington@adp.uchc.edu

Endnotes

¹ Source: Federal Health Resources and Services Administration

² Source: Connecticut Department of Labor

³ Source: Connecticut Department of Higher Education

⁴ Aiken L, Clarke S, Sloane D, et al. Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. *JAMA*. 2002; 288:1987-1993. Needleman J, Buerhaus P, Mattke S, et al. Nurse-Staffing Levels and the Quality of Care in Hospitals. *New England Journal of Medicine*. 2002; 346:1715-1721. Aiken L, Smith H, and Lake E. Lower Medicare Mortality Among a Set of Hospitals Known for Good Nursing Care. *Medical Care*. 1994; 32: 771-187. Unruh L. Licensed Nurse Staffing and Adverse Events in Hospitals. *Medical Care*. 2003; 41: 142-152.

⁵ Komaromy M., Grumbach K., Drake M et al. The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. *New England Journal of Medicine*. 334 (20). 1996; pp 1305-1310.

⁶ Smedley B, Smith A, and Nelson A. *Unequal Treatment Confronting Ethnic and Racial Disparities in Health Care*. National Academy Press, Washington, D.C. 2003.



CONNECTICUT WOMEN'S HEALTH CAMPAIGN

c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Need for Consumer Protections Under Preferred Drug Lists for All ConnPACE and State Assistance Recipients

The Connecticut Women's Health Campaign

African American Affairs Commission
American Cancer Society
American Heart Association
Commission on Aging
CT Association for Human Services
CT Association of Nonprofits
CT Association of Substance Abuse Agencies
CT Breast Cancer Coalition, Inc.
CT Citizen's Action Group
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Yale University School of Medicine

The Connecticut Women's Health Campaign supports legislation that will ensure basic consumer protections under Preferred Drug Lists with prior authorization for all ConnPACE, Medicaid and State Administered General Assistance (SAGA) recipients. CWHC supports this legislation because these protections are essential to maintaining and increasing access to essential health care for women, and will apply to a large number of women across all age groups and with varying health care needs.

The Problem

Connecticut is about to implement a Preferred Drug List (PDL) with Prior Authorization (PA) required for all unlisted drugs on all fee-for-service (elderly and disabled) Medicaid, ConnPACE and SAGA recipients. The law under which the Department of Social Services is doing this has no consumer protections except for an exclusion from PA for "mental health-related" drugs and anti-retrovirals (certain, but not all, HIV-related drugs).

However, Preferred Drug Lists have already been implemented for three of the four plans covering Connecticut's Medicaid managed care population, which consists of about 275,000 children and their parents or other caretaker relatives, the vast majority of whom are women. Significant harm has resulted for these families and is ongoing. Part of the harm is because providers have had time-consuming experiences trying to get Prior Authorization for patients who need non-listed drugs, and therefore are unwilling to go through the process, even where they believe a non-listed drug is superior for a given patient. However, more of the harm is because prescribers have difficulty keeping track of which drug is on a specific list for a given health plan in a given month. This is because there are thousands of drugs on and off each preferred drug list, each Preferred Drug List is different, and the lists are frequently changed.

As a result, prescribers routinely write prescriptions for non-listed (prior authorization-required) drugs without first requesting prior authorization, and their patients then go to the drug store with these prescriptions. When the pharmacist enters the request for payment through the on-line system all pharmacies use, those drugs are rejected. In the vast majority of cases, the patient then walks out with no drug at all (not simply with a cheaper drug

that may not be as effective), because these low-income individuals generally have no cash on hand to pay on their own. Further, the pharmacists do not have the time or knowledge necessary to address the problem, and the temporary supplies that are supposed to be available are almost never provided.

Data

Preferred Drug Lists are already being used for families enrolled in three of the four participating Connecticut Medicaid HMOs, with severe consequences:

Data from just one of those HMOs shows that, **each month**, about 2,600 prescriptions are rejected at the pharmacy, with temporary supplies provided within 24 hours in fewer than 3% of these cases, or about **30,200 rejections per year without any temporary supplies**. [Supplemental Discovery Response by Defendant Health Net, Inc. in Karen L. v. Health Net and DSS, No. 3:99cv2244 (CFD)(D. Conn.)(June 19, 2003).]

This particular Medicaid HMO has approximately 34% of the Medicaid managed care recipients in Connecticut subject to PDLs.

It is anticipated that the pharmacy rejection rates will increase substantially in Connecticut when PDLs are applied to the elderly and disabled low-income populations, as they rely more heavily on daily medications than do the family Medicaid populations.

Also, in Florida, where a preferred drug list was implemented without any due process protections: “over 35,000 [Medicaid] recipients **in a single recent month** were denied coverage of their prescription drugs or the opportunity for a hearing, including **21,974 recipients [63%] who received no drug at all in the same therapeutic class**.” [Hernandez v. Medows, Case No. 02-20964, 2002WL 31060425, *3 (S.D.Florida Aug. 26, 2002)(emphasis added).]

What Can Be Done?

Connecticut should require that basic consumer protections be mandated whenever the Department of Social Services, or a managed care organization under contract with it, chooses to use a Preferred Drug List with Prior Approval required for non-listed drugs. This would include any of the three state assistance programs, including both Medicaid managed care and Medicaid fee for service (where a PDL has not yet been implemented). The basic protections include:

- a simpler prior authorization process;
- mandated temporary supplies at the pharmacy whenever prescriptions for non-listed drugs are presented;
- written notice to both prescribers and patients as to the reason why only temporary supplies are being provided and how to correct the problem;
- expedited appeals with the right to maintain access to a drug during the appeal process;
- a prohibition on repeated Prior Authorization for the same drug and patient; and
- mandated studies of resulting access problems.

Legislation is required to ensure such protections. It is anticipated that these protections will not result in significant costs since the protections will ensure temporary access to drugs that are already covered under the respective programs and already have valid prescriptions in place. In most cases, where an alternative drug which is on the list is just as safe and effective as the non-listed drug, switching to such drug still will occur. Providing these protections will avoid the far more costly alternative treatments in emergency departments and in-patient hospital wings, which often result when access to needed drugs is blocked.

For additional information, please contact:

Sheldon V. Toubman

New Haven Legal Assistance Association

426 State Street

New Haven, CT 06510

ph: (203) 946-4811, ext. 148

fax: (203)498-9271

e-mail: stoubman@nhlegal.org



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c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

SAGA

Critical Women's Health Program

The Connecticut Women's Health Campaign

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The Connecticut Women's Health Campaign supports universal coverage that is affordable and accessible for all people regardless of income, age, employment status immigration status or location of residence. For this reason the CWHC supports full funding for health care safety net programs, including funding to restore the SAGA (State Administered General Assistance) medical program.

The Problem

SAGA provides health care for approximately 29,000 of Connecticut's poorest residents. Health care coverage through SAGA is critical to low-income women in Connecticut, as 40% of the recipients are women.¹ Access to medical services that are covered under this program are limited. Connecticut's SAGA medical recipients often have complex medical needs. Currently, vision care, podiatry, home health care, physical therapy, occupational therapy and speech therapy are not covered.² Moreover, the viability of institutions and providers to deliver care is severely threatened.

For SAGA recipients, the SAGA Medical Program is the only access to health care for these individuals whose income is limited to \$5,724 a year and assets are limited to \$1,000. Non-emergency medical transportation which allows these individuals to get consistent health care is also not covered. Many are disabled and do not have transportation. Some are waiting for a final SSDI/SSI and Medicaid eligibility determination, which would provide transportation; however this process can take 8 months to two years to accomplish. Under the new restructured system many SAGA recipients must go out of town to see a primary care physician. For these recipients, who often have complex medical needs, being required to travel even a few miles can be a complete barrier to care.

Of equal importance, the restructured SAGA program that went fully into effect on October 1, 2004³ will cause serious financial hardships on Connecticut hospitals and Federally Qualified Health Centers (FQHCs) that will create real barriers to the delivery of and access to health care. The newly implemented system caps funding to the hospitals and the Federally Qualified Health Centers, which are statutorily designated with delivering medical care. Connecticut hospitals stand to lose up to \$22 million a year under the new SAGA restrictions and FQHCs will lose between \$2 million and \$5 million a year. These losses threaten the ongoing financial viability of essential non-profit health care providers.

What Can Be Done?

Legislation must be in place to protect our hospitals and health care centers and ensure access to health care for our poorest residents. Specifically, Connecticut should:

- Remove language that caps funding
- Restore non-emergency medical transportation as a covered service
- Restore vision care, home health care, physical therapy, occupational and speech therapy, and podiatry as covered services
- Provide protections for SAGA patients under managed care.

In sum, Connecticut's SAGA Medical Program is an integral safety net program and lifeline for vital health care services.

For additional information, please contact:

Laurie Julian, J.D., M.P.H.
Government Affairs
Connecticut Primary Care Association
90 Brainard Road
Hartford, CT 06114-1685
(860) 727-0004
ljulian@ctpca.org

Lisa Sementilli
Connecticut Voices for Children
33 Whitney Avenue
New Haven, CT 06510
(860) 548-1661
lisaS@ctkidslink.org

Gretchen Vivier
Director
Health Care for All Coalition
139 Vanderbilt Ave.
West Hartford, CT 06110
(860) 947-2211
gvivier@ccag.net

Endnotes

¹ DSS Data.

² June 30, Special Session, P.A. No. 033.

³ Conn. Gen. Stat. Section 17b-257 as amended by Section 43 of P.A. 03-03 (June Sp. Sess.).



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Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Support the Next Step to Increase Supportive Housing in Connecticut

The Connecticut Women's Health Campaign

African American Affairs Commission
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Commission on Aging
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Yale University School of Medicine

The Connecticut Women's Health Campaign supports the expansion of supportive housing for homeless families in order to help them address substance abuse, violence, mental illness and to stabilize their lives.

Residents of supportive housing receive individualized assistance including healthcare, transportation, counseling, employment advice, and help budgeting or balancing a checkbook.

The Problem

Last year, 33,000* people were homeless in Connecticut, and 13,000* of them were children. Although some were able to live with friends or family, nearly 17,000* needed care in shelters. The number of people turned away from shelters last year increased by 38%.

In FFY 2003, 16,793 individuals sought beds in homeless shelters, and 37,500 were turned away due to lack of available beds.¹

Homelessness is fast becoming a women's issue as families – not just individual adults – are now seeking shelter. Fourteen hundred and six (1,406) families sought shelter. Of those families, single females headed 85.9%, and 10.6% were two-parent families. Eleven thousand and sixty-six (11,066) single adults sought shelter. Of that population, 24.3% were women.²

In the past year, there has been a decline in all categories mentioned above, except single females, which has increased by 5.9%.³

Shelter Services	FFY 2002	FFY 2003	Numbers (+/-)	Percentage (+/-)
Families	1,506	1,406	-100	-6.6%
Single Female	1,259	1,206	-53	-4.2%
Single Male	74	48	-26	-35.1%
Two Parents	168	149	-19	-11.3%
Single Adults	11,251	11,066	-185	-1.6%
Female	2,545	2,694	+149	+5.9%
Male	8,705	8,369	-336	-3.9%

The facts

A study of the first supportive housing built in Connecticut showed that inpatient Medicaid expenses fell 71%* for people who moved into supportive housing.

Supportive housing costs \$36* a day, about the same as the cost of a homeless shelter. In contrast, incarceration costs \$83* a day, residential drug treatment costs \$103 a day and inpatient psychiatric or medical care can cost more than \$1,000* per day.

The study also showed that supportive housing is a good investment. It returns \$3.43 in new economic activity for every \$1 invested. Also the value of property surrounding the supportive housing sites examined in this study went up.

What can be done?

The lasting and proven answer to homelessness is supportive housing, particularly for women and their children. In case after case, women who have suffered from substance abuse, mental illness, battering and family dislocation have been able to stabilize their lives and find independence in supportive housing.

Supportive housing in Connecticut has been so successful that the General Assembly is being asked in the coming legislative session to finance 1,000 new units, the first large step toward the "Reaching Home" Campaign's goal of 10,000 units over the next 10 years.

For additional information, please contact:

Partnership for Strong Communities
227 Lawrence Street
Hartford, CT 06106
(860) 244-0066
www.ctpartnershiphousing.com

Corporation for Supportive Housing
129 Church Street, Suite 608
New Haven, CT 06510
(203) 789-0826
www.csh.org

Sources:

Estimates of homelessness in Connecticut were derived from: Burt, Martha, et al. *Helping America's Homeless: Emergency Shelter or Affordable Housing?* Washington, D.C.: Urban Institute Press. 2001.

*Connecticut per diem costs: Average daily rate ...

- inpatient hospitalization (for a person with HIV/AIDS): \$1,287 (Yale New Haven Hospital, 2001);
- inpatient psychiatric care (State-operated facility): \$1,089;
- inpatient psychiatric care (private facility): \$554;
- intensive residential substance abuse treatment: \$103 (Department of Mental Health and Addiction Services, 2002);
- nursing home care: \$232 (Office of Policy and Management, 2002);
- incarceration: \$83 (Office of Legislative Research, 2001);
- supportive housing: \$36 (Program Evaluation Report for Connecticut Supportive Housing Demonstration Program, 1999 – obtainable through the Corporation for Supportive Housing).

¹ CT Department of Social Services Homeless Shelter Report for Federal Fiscal Year 2003-October 2002-September 2003. CT Coalition to End Homelessness, available at www.cceh.org/facts.htm

² CT Department of Social Services Homeless Shelter Report Annual Demographic for Federal Fiscal Year 2003. CT Coalition to End Homelessness, available at www.cceh.org/facts.htm.

³ Comparison of reports *Annual Homeless Shelter Demographic Report, FFY 2002 (Oct. 2001-Sept. 2002) Family Composition* versus *CT Department of Social Services Homeless Shelter Report Annual Demographic for Federal Fiscal Year 2003*. CT Coalition to End Homelessness.



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c/o Permanent Commission on the Status of Women

18-20 Trinity Street Hartford, CT 06106

Phone: (860) 240-8300

Fax: (860) 240-8314

E-mail: pcsw@cga.ct.gov

Website: www.cga.ct.gov/pcsw

Connecticut Women's Health Campaign Statement of Principles

The Connecticut Women's Health Campaign

African American Affairs
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Medicine

UNIVERSAL COVERAGE which is affordable and accessible for all people regardless of income, age employment status, immigration status or location of residence. This is especially important to women who comprise the largest group of poor people in the country and have the highest proportion of part-time workers, and especially for women of color who face additional barriers because of racism. To make the promise of universal coverage real for all women, the new health care plan must include a cap on premiums and co-pays based on a percent of income model.

COMPREHENSIVE BENEFITS PACKAGE which covers a full range of services including but not limited to reproductive health care (including contraception, prenatal care and abortion), mental health and substance abuse treatment, preventive health care (including early detection services such as mammography, PAP smears, pelvic exams, and testing for HIV and STD's), acute and long-term care, and rehabilitative care.

INCLUSION OF A WIDE RANGE OF HEALTH CARE PROVIDERS AND SETTINGS. Providers should include mid-level practitioners such as midwives and nurse-practitioners, and settings should include neighborhood health centers, family planning clinics and other programs that provide effective culturally and linguistically appropriate health care.

INCREASED ATTENTION TO WOMEN'S HEALTH NEEDS IN THE NATIONAL RESEARCH AGENDA, especially for the prevention and treatment of breast cancer and other medical conditions which disproportionately affect women, and the guaranteed inclusion of women in clinical trials and research samples for all medical conditions that affect women. Also, states should be required to collect data about women's health.

EQUAL REPRESENTATION OF WOMEN AT ALL LEVELS OF DECISION-MAKING, RESEARCH AND SERVICES DELIVERY, including those of different races, ages, income levels and sexual orientation. In addition, health care consumers should be included in the decision-making process.

CONFIDENTIALITY WHICH IS ESSENTIAL TO PROTECT ACCESS for all people including, but not limited to minors, people with HIV infection, people seeking reproductive health care, and survivors of domestic or sexual violence.